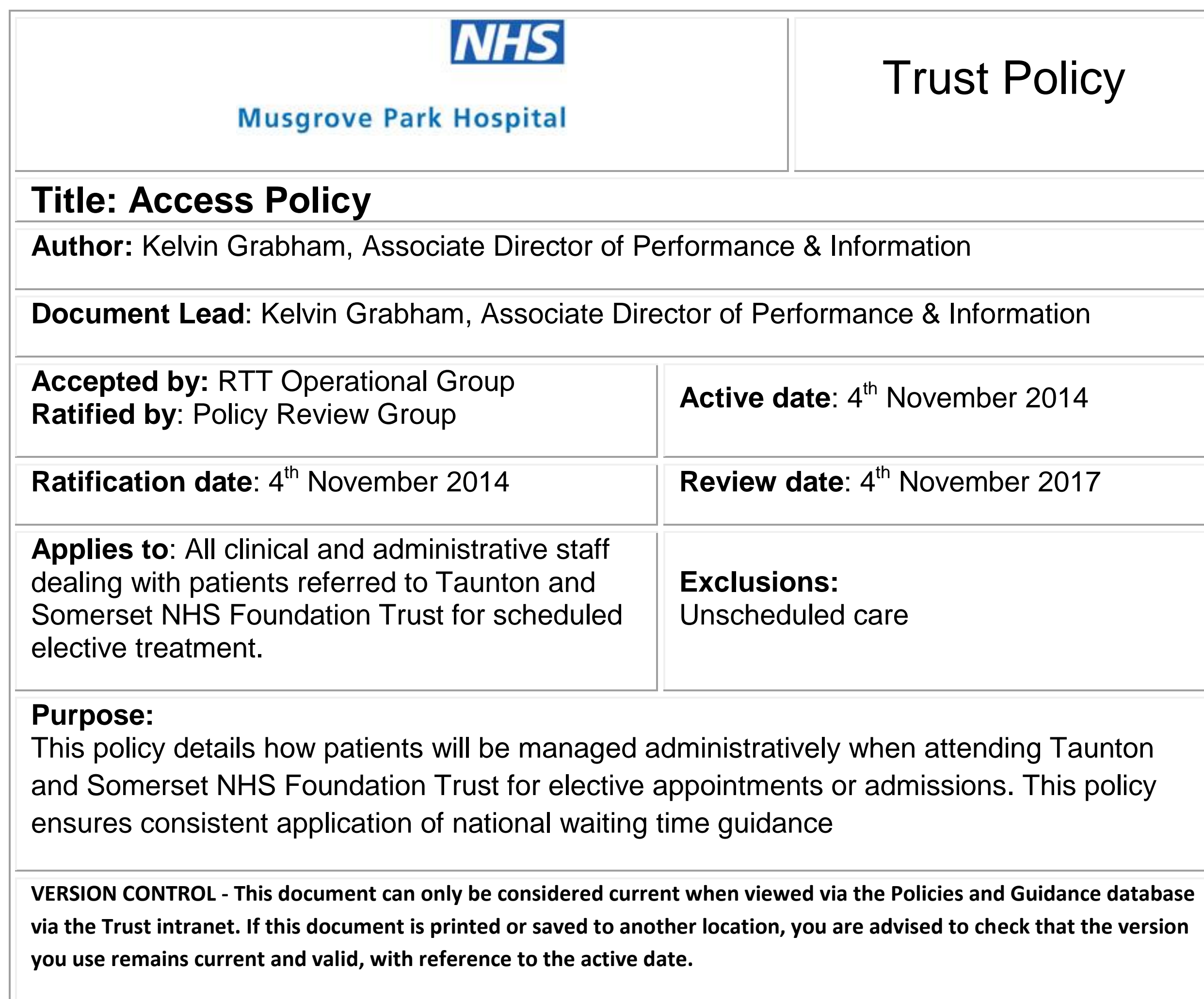

Musgrove Park Hospital	Trust Policy
Title: Access Policy	
Author: Kelvin Grabham, Associate Director of Performance & Information	
Document Lead: Kelvin Grabham, Associate Director of Performance & Information	
Accepted by: RTT Operational Group **Ratified by**: Policy Review Group	**Active date**: 4th November 2014
Ratification date: 4th November 2014	**Review date**: 4th November 2017
Applies to: All clinical and administrative staff dealing with patients referred to Taunton and Somerset NHS Foundation Trust for scheduled elective treatment.	**Exclusions:** Unscheduled care
Purpose: This policy details how patients will be managed administratively when attending Taunton and Somerset NHS Foundation Trust for elective appointments or admissions. This policy ensures consistent application of national waiting time guidance	
VERSION CONTROL - This document can only be considered current when viewed via the Policies and Guidance database via the Trust intranet. If this document is printed or saved to another location, you are advised to check that the version you use remains current and valid, with reference to the active date.	

Key Points:

- The Access Policy must be followed to ensure that waiting times are managed fairly and correctly in line with national guidance. Inability to comply with these rules must be escalated to your Line Manager.

- This policy will be issued to all staff who are accountable for delivery of Referral to Treatment (RTT) waiting time targets. Generic objectives will also be issued by the line manager through the appraisal process, to ensure staff compliance with this policy at all times.

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1. INTRODUCTION

1.1 This policy has been developed to support staff to accurately record and report on referral to treatment waiting times. The guidance set out in this policy must be followed by every member of staff to ensure patients are being treated fairly and consistently within the definitions of the national guidance.

1.2 This policy applies to all staff who are responsible for recording waiting times information on Trust systems, for validating waiting times and for reporting waiting times internally or externally. It is not, however, intended as a technical guide for entering waiting times data on Cerner.

1.3 This policy must be read in conjunction with the national guidance on RTT waiting times. Compliance with this policy and national RTT guidance will be routinely monitored through the RTT Operational Group and non-compliance raised with the relevant Directorate Manager to resolve.

1.4 Please note that this policy complements the separate Trust Cancer Access Policy.

2. DUTIES AND RESPONSIBILITIES

2.1 This policy applies to all clinical and administrative staff dealing with patients referred to Taunton and Somerset NHS Foundation Trust for scheduled elective treatment. Specific responsibilities are:

- All staff responsible for offering appointment dates to patients will ensure they comply with this policy;
- All staff entering data onto Trust systems will ensure it is complete and accurate in reflecting the rules included in this policy;
- The RTT Validation Team will carry out regular validation checks on RTT data against the Access Policy and raise exceptions with individual staff or Directorate Managers for resolution;
- Directorate Managers will ensure areas of non-compliance within their directorate are resolved and continued non-compliance by members of their staff are addressed;

- The Associate Director of Performance & Information will be responsible for regularly reviewing the policy against national or local guidance and updating as required to ensure consistency.

3. NON-ADMITTED PATHWAYS (OUTPATIENTS)

Referrals

3.1 Typically a new episode of care will be generated from a GP referral to a hospital consultant. For the purposes of RTT recording patients referred from the following sources are also included:

- Nurse Practitioners;
- GPs with a specialist interest;
- Allied Health Professionals;
- Optometrists and Orthoptists;
- A&E, Minor Injuries Units and Walk in Centres;
- Consultants;
- Dentists.

3.2 For referrals via Choose and Book the 18-week clock starts from the point at which the patient converts their UBRN number in order to book their outpatient appointment, or from the time that their referral is received by a Specialist Triage Service for onward referral to a secondary care provider. Patients who have been booked under Direct Booking rules will have a referral created on Cerner by the Choose and Book software.

3.3 Non-Choose and Book referrals need to be added to Cerner with a date which must be when the hospital received the referral. For patients whose primary care referral has been received via the post, the 18 week clock will commence at the point that the referral has been received by the hospital. The referral must then be added to Cerner within **one working day** of receipt. Referrals from areas such as Accident & Emergency into an elective pathway are classed as external referrals. The 18 week clock starts from the point at which the referral is made from the A&E department.

3.4 Referring clinicians will have the option to refer to a specific consultant-led team where necessary or at the request of a patient. Where no specific specialist requirements

apply then the referring clinician will be encouraged to refer to a service rather than an individual. This will ensure that there is an equalisation of waiting lists and that the maximum waiting time for all patients will be reduced.

Exceptional Treatments

3.5 Some treatments are not routinely funded by commissioners and require prior approval. These procedures are logged centrally by the Admissions Department. The Somerset CCG guidance for clinicians, which details the criteria for procedures not routinely funded and the referral form for CCG prior approval can be found on the Trust's Intranet site using the following link:

http://intranet.tsft.nhs.uk/trustmanagement/IndividualFundingReviewExceptionalTreatments/tabid/7484/language/en-GB/Default.aspx

Any referral for an exceptional treatment will therefore not be accepted until funding has been agreed by commissioners.

As a general principle patients should not be added to a waiting list for treatment that has not been approved by the commissioner.

Internal Referrals

3.6 Where a consultant has made a referral to another consultant for a second opinion or further assessment, the patient wait for this second appointment will be included in the overall calculation of length of wait for the purposes of 18-week measurement. If this internal referral is for an unrelated (new) condition, a new clock would start at the point the referral was received by the second consultant.

Adding Patients to the Outpatient Waiting List

3.7 Choose and Book patients booked under the Direct Booking rules will not require an outpatient waiting list entry. Choose and Book patients booked under the Indirect Booking rules will require an outpatient waiting list entry. The date on list will be calculated from the date that the patient contacted the Booking Management Service or appropriate department to arrange their appointment. Non-Choose and Book patients will also require a waiting list entry. The date on list will be calculated from the

date the referral was received by the hospital. Where a waiting list entry is required this must be added, fully triaged by a clinician, within **two working days** of either the patient contacting the hospital or receipt of the referral.

General Principles for Booking

3.8 The following general principles apply to all patients referred to the Trust:

- All patients must be seen in order of clinical priority and length of wait;
- Patients must be offered at least two reasonable appointment dates, where a reasonable offer is a date more than three weeks from the time of the offer being made. These dates must be recorded on Trust systems;
- If two reasonable offers are declined for either a new or follow-up outpatient consultation and the patient is unable to attend an alternative appointment within three weeks of the offer being made, the patient will be discharged to their GP;
- No patient waiting for an outpatient appointment or diagnostic appointment can be suspended or paused.

Confirmation of appointments

3.9 All patients (including Choose and Book), regardless of their method of booking, must be sent a letter or an appointment card confirming the time, date and location of their appointment. Where appropriate, additional information required for their appointment, e.g. health questionnaires etc., should also be included at this stage.

Cancellations

3.10 ***Patient cancellations:*** A patient is able to cancel their appointment up to 24 hours before the appointment time without being discharged back to the referrer. If a patient cancels more than two appointments within their RTT pathway they will be discharged to the referrer.

3.11 ***Hospital cancellations:*** A minimum of 6/8 weeks notice (depending on contract) of annual or study leave is required for clinic cancellation or reduction. No sessions are to be cancelled once patients are booked on them, unless there are exceptional

circumstances. All cancellations or reductions must be authorised by the Directorate Manager.

Did Not Attends (DNAs)

3.12 All patients (with the exception of children, vulnerable adults and cancer patients) who do not attend their outpatient appointment will be discharged back to the referrer.

Non-admitted (outpatient) Clock Stops for Treatment

3.13 A clock stops when first definitive treatment starts, as defined as being an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. The date that first definitive treatment starts will stop the clock - this may be either in an interface service or a consultant-led service. Often, first definitive treatment will be a medical or surgical intervention. However, it may also be judged to be other elements of the patients care, for example, the start of counselling. In all cases, what constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Clock Stops for Non-Treatment

3.14 Where a decision not to treat is made then this decision (and communication with the patient) stops a waiting time clock. This results in the patient being discharged back to the care of their GP (and/or other initial referrer). Where there is a decision made not to treat, but to retain clinical responsibility for the patient within the provider organisation (for regular outpatient follow-ups etc) then it may be more appropriate to record this as active monitoring (see 2.16 below) although both have the same effect of stopping the patient's clock.

Further Treatment in Primary Care

3.15 A clock stops when it is communicated to the patient and referrer that it is clinically appropriate to return the patient to primary care for any non-consultant-led treatment.

Active Monitoring (or Watchful Wait)

3.16 In many pathways there will be times when the most clinically appropriate option is for the patient to be actively monitored over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time. When a decision to commence a period of active monitoring is made and communicated with the patient, then this stops a patient's waiting time clock. Active monitoring may be applied where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. The maximum period of active monitoring will be 12 months. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is a clinical reason to delay treatment/admission then a waiting time clock would usually continue.

3.17 Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms). However, it would not be appropriate to use patient initiated active monitoring to stop patients' clocks where a patient does want to have a particular diagnostic test/appointment or other intervention, but wants to delay the appointment.

Thinking Time

3.18 If a patient is given 'thinking time' by a consultant then if this is short, then the RTT clock should continue to tick. An example is where invasive surgery is offered as the proposed first definitive treatment but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery. If a longer period of "thinking time" is agreed, then active monitoring is more appropriate.

Recording of Outpatient Outcomes

3.19 The clinician who sees the patient in Clinic is responsible for ensuring that **all sections** of the Outpatient Outcome form are completed. Information from these forms will then be entered into Cerner **within 24 hours** of patient attendance.

Outpatient Waiting List Management

3.20 Clinical priority must be the main determinant when patients are seen as outpatients or admitted as inpatients. Patients of the same clinical priority will be seen in chronological order. Patients may only be categorised as suspected cancer, urgent or non-urgent (routine). Where service requirements demand the grouping of patients (e.g. same procedure lists or specific surgeon only being able to do certain procedures), patients may be taken out of chronological order providing this does not significantly delay the patients', or other patients', treatment.

3.21 All waiting lists and activity must be recorded on an appropriate electronic clinical system.

3.22 All staff must adhere fully to the Trust's annual leave policy. Medical staff and related rotas must be completed at least **six/eight** weeks in advance (in accordance with contract) to ensure the effectiveness of booking procedures and protocols. Medical staff job plans must be reviewed on a regular basis to ensure that capacity and demand flows are in balance to achieve national and local waiting time targets.

4. ADMITTED PATHWAYS (INPATIENTS)

Adding Patients to an Inpatient Waiting List

4.1 The decision to treat a patient must be made by a Consultant, or under an arrangement agreed with the Consultant, with the patient's agreement. Patients must not be added if:

- They are unfit for the procedure;
- Further investigations are required prior to the procedure;
- Patients are not clinically or socially ready for an admission.

Where, at the point of decision to add to the waiting list, a patient is not fit, ready or able to come to the Trust for the procedure they should be discharged back to the referrer.

4.2 If a patient is listed by two specialties at the same time a clinical decision must be made as to which procedure should take priority. When deemed fit following the first procedure the patient should contact the Trust to be listed for the second procedure.

4.3 Patients will agree an admission date through face-to-face contact, by letter or by telephone. All patients will receive written confirmation of the date, time and location of their admission. Where patients cannot be contacted they will be discharged to their GP.

General Principles for Booking

4.4 The following general principles apply to all patients booked onto an inpatient waiting list:

- All patients must be seen in order of clinical priority and length of wait;
- Patients must be offered at least two reasonable appointment dates, where a reasonable offer is a date more than three weeks from the time of the offer being made. These dates must be recorded on Trust systems;
- War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

Patient Initiated Delays

4.5 With effect from 1st October 2015 pauses (suspensions) should no longer be applied to waiting times clocks for any RTT pathways. Whilst many patients will want to be seen at the earliest opportunity the 92% incomplete pathway target allows a tolerance for patients choosing to wait longer than 18 weeks. As such patients must be allowed to plan their treatment around their personal circumstances as long as any delay is clinically appropriate.

4.6 As a general rule delays of up to three months should be accepted as long as the responsible clinician is happy that this is clinically appropriate. For any patient-requested delays of more than three months, or for any requests for delays for patients who have already waiting over 6 months, this must be reviewed on an individual basis by the relevant Directorate Manager and clinician.

4.7 If at any point the clinician is not satisfied that the proposed delay is appropriate then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI should be agreed. If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interests of the patient, which may include discharging the patient back to the care of their GP if appropriate.

4.8 Where a patient wishes to delay treatment this must be recorded to ensure that when they become available they are treated in priority order. Open-ended patient-initiated delays must not be allowed – an available date must be agreed with the patient at the point they indicate their wish to delay treatment. A list of patient-initiated delays should be reviewed regularly and, when available for treatment following a delay, it is good practice to agree a TCI with patients rather than send them an appointment (to reduce the risk of a cancellation or DNA to an already long-wait pathway).

Cancellations

4.9 Where a patient’s admission has been cancelled because of lack of beds or equipment, issues with theatre time or facilities, or staffing levels due to sickness this should be recorded as a hospital cancellation and the patient’s RTT wait will continue.

4.10 Whenever the hospital cancels an operation or procedure for non-medical reasons, either after the patient has been admitted or on the day of surgery, the patient should be given a re-arranged date within **28** days of their original TCI date or within the breach date according to the 18 week pathway (whichever is sooner).

4.11 In some circumstances, the patient is admitted to hospital but for clinical reasons has to be sent home and their treatment cancelled. This automatically removes the patient from the waiting list. If the patient still requires treatment, they will need to be re-instated to the waiting list and their clock would continue from the original date.

4.12 Patients who cancel operations more than 24 hours before the date of operation should be informed of the likely arrangements for their future admission. Wherever possible, they should be given a re-arranged date at the time of the cancellation that is within the 18 week waiting time standard. Where patients cancel twice or more, they will be removed from the waiting list and returned to the referrer, and a letter will be sent to the referrer explaining the reason.

Did Not Attends (DNAs)

4.13 Patients (with the exception of children and vulnerable adults) who do not attend their preoperative assessment appointment or admission (TCI) date for elective admission will be discharged back to the referrer. The Trust must be able to demonstrate that the appointment offered was reasonable and discharging the patient represented no clinical risk. A letter will be sent to the consultant, patient and their GP explaining the decision to refer the patient back to their referrer.

Unfit Patients

4.14 No patient should be added to the waiting list if they are unfit for their treatment at the time of adding. It is however recognised that patients may become unfit after they have been listed. In this case, an assessment must be made of the likely duration of the period of unavailability.

- **Two weeks** or less: must be absorbed into the overall patient waiting time, the patient remains the responsibility of Musgrove Park Hospital;

- Over **two** weeks: the patient must be discharged back to the care of their GP for re-referral into the preoperative assessment clinic (POAC). In this instance clear guidelines must be given to the GP regarding patient condition to warrant re-referral. The GP will take over care of the patient until they are fit for re-referral at which point the GP will contact Admissions by letter to re-list and POAC as appropriate.

Criteria for Adding Patient to Planning Waiting Lists

4.15 Planned Waiting List patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment. These patients are not waiting for a first treatment date, they have commenced their treatment and there is a plan for the subsequent stages of that treatment. Second stage of bilateral treatment must be planned to be carried out without undue delay of the initial stage of treatment, unless clinically indicated otherwise. When dealing with the second side of Bilateral patients (e.g. second eyes/hips/knees), once the patient is declared fit for the second side, a new active elective waiting list entry should be added to Cerner using the date that the

patient is declared. fit for the second stage of treatment as the date on list. A new clock will start from the date the patient is declared fit.

Inpatient Waiting List Management

4.16 Waiting Lists must be kept up to date by staff using data received from various sources. Patients must be listed promptly. All elective admissions should be booked and admitted through the Cerner waiting list. It is only **emergency** admissions that are not required to be placed on a waiting list.

4.17 A confirmation letter must be sent to the patient of their TCI date with the appropriate information sheets enclosed. To Come In (TCI) letters should be produced using Cerner and should identify a named contact.

Admissions from Tertiary Services

4.18 All patients being referred on from another provider will be referred via the standard Inter Provider Transfer form. This information must be added to Cerner **within 24 hours** of receipt. All patients being referred on to another provider must be referred via the standard Inter Provider Transfer form for continuation of the same patient pathway.

Reinstating a Patient on to the Waiting List

4.19 In the event of a patient requiring to be returned to the waiting list, the previous waiting list entry and 18 week clock must be reactivated from the original referral date rather than establishing a new entry. Where these patients have been reinstated because of a non-clinical cancellation e.g. list overrun or emergency trauma, the 28 day rule applies.

Transfers Between Clinicians for Administrative Reasons

4.20 Where transfers between clinicians are required (for instance to cover sickness or planned leave) patients listed as ‘any to do’ can be transferred to ensure equalisation of waiting lists and a reduction in waiting times for patients. Where patients have made a specific choice of clinician, transfer must be agreed by the patient and the original and receiving consultant must be notified. Any refusal of the patient to be transferred will not affect their waiting time.

Transfers Between Clinicians for Clinical Reasons

4.21 ***Consultant to consultant referral for the same care pathway***: The consultant will refer a patient to a consultant colleague within the same specialty, or to a different specialty, for the same care pathway, in the usual manner.

4.22 ***Consultant to consultant referral for a different care pathway (non-urgent cases)***: Where the consultant to whom the patient has been referred identifies a different medical problem which, in his/her opinion, requires review by another clinician, the patient will be referred back to their GP.

4.23 ***Urgent cases (including suspected cancer):*** Where cancer or any other urgent condition is suspected, the consultant will refer a patient to a consultant colleague in the usual way ensuring they are clearly identified as urgent or cancer.

Transfers to Private (or alternative) Providers

4.24 As part of the NHS Constitution the patients' healthcare commissioner may offer patients waiting over 18 weeks the opportunity to be seen by private (or alternative) providers. The Trust will record any transfer requested by the commissioner on behalf of the patient in Cerner. All transfers to a private provider subcontracted by the Trust to provide additional capacity must be done in conjunction with the operational policy for sending patients to the private sector. It is important to ensure that patients are not removed from the waiting list until treatment with the private provider has been confirmed as completed (where the treatment date is the clock stop). Please note this does not include patients who have elected to receive private treatment.

Transfers from Private Providers

4.25 Where a patient has been seen as an outpatient privately and then referred to the NHS for inpatient treatment, the 18 week clock starts from the date of referral to the NHS hospital.

5. DEFINITIONS

5.1 This section includes brief definitions for different types of elective activity carried out by the Trust.

Elective Inpatient:

Patient is admitted electively to a hospital bed and will require an overnight stay in hospital.

Day Case:

Patient is admitted electively to a hospital bed during the course of a day, with the intention of receiving care or treatment that can be completed in a few hours, so that they do not require remaining in hospital overnight and who are discharged as scheduled.

Outpatient procedure:

Patient is treated electively in a non-theatre environment where treatment and discharge is completed within 3 hours. Patients do not require a recovery period greater than 20 minutes prior to discharge or recovery in a nursed bed.

Diagnostic admissions:

Patient is admitted electively with the admission intended purely for investigation or tests (the purpose of the admission is to diagnose rather than plan any required treatment). These admissions do not stop an eighteen week clock unless treatment is subsequently given or the patient is referred back to their GP.

Diagnostic outpatients:

Patient’s appointment is intended purely for investigations or test with a purpose to diagnose then plan any required treatment.

Ward Attender:

Patient who has an appointment for an attendance on the ward with a nurse or technician.

6. MONITORING ARRANGEMENTS

6.1 Compliance with this policy (and national RTT guidance) will be routinely monitored through the weekly RTT Operational Group and non-compliance raised with the relevant Directorate Manager to resolve.

6.2 The RTT Validation team carry out a continuous series of validation checks on RTT data against the Access Policy rules and raise any issues with individual members of staff or managers as necessary. The team escalate any significant breaches of the policy to the RTT Operational Group. Compliance against the policy is measured by reviewing performance against the following indicators:

- Number of missed admin stops;
- Patient initiated delays;
- DNA and cancellation rates by specialty.

6.3 The Performance and Information Team also monitors performance against the following national waiting times targets:

- 90% of admitted patients and 95% of non-admitted patients treated within 18 weeks of referral (as per the NHS Constitution);
- A maximum wait of 6 weeks for a diagnostic test;
- 92% of incomplete pathways (both admitted and non-admitted) to remain within 18 weeks.

7. REFERENCES

7.1 The Trust Access Policy must be read in conjunction with the national Referral to Treatment Consultant-Led Waiting Times rules suite. This rules suite gives more detailed information about what constitutes a clock start and a clock stop, and gives numerous case studies of how to apply the guidance in different situations. The rules suite can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255582/RTT_Rules_Suite_April_2014.pdf

APPENDIX A

Summary of National RTT Rules

The referral to treatment consultant-led waiting times rules suite: clock starts, pauses and stops

What causes a clock start?

Any eligible professional that refers a patient:

- directly to a consultant-led service; or
- to an intermediary service offering clinical triage, assessment and, or treatment.

Patient rebooks after failing to attend a first appointment.

A self referral (where this has been locally agreed).

A decision to treat following a period of active monitoring.

A patient becomes fit and ready for the second of a bilateral procedure.

A decision to start a substantially different treatment.

When does the clock start?

For paper referrals:

- When the referral is received by the trust, if directly referred to a consultant-led service. If through an intermediary service – when received by that service.

For 'Choose and Book' referrals:

- When the patient's unique booking reference number is converted to a hospital appointment.

When a patient rebooks following a first appointment that they failed to attend and that nullified their clock:

- The date the new appointment is agreed.

After a period of active monitoring/for a substantially different treatment/when patient becomes fit for treatment:

- The date the decision to treat is made.

What causes a clock pause?

A clock can only be paused (and reported to NHS England) where a decision to admit has been made and the patient has declined at least two reasonable appointment offers.

For social reasons such as:

- holidays;
- care responsibilities; or
- work commitments.

When does the pause start/stop?

The pause starts with the earliest reasonable offer made by the trust.

The pause is stopped when the patient makes themselves available for treatment. For example, a patient who has declined two reasonable offers of 4 June and 7 June will have the clock paused from 4 June (the earliest reasonable offer date). The patient says they would be available after 15 July, but the first date the provider can offer is 18 July – in this case the clock should restart from 15 July – the date the patient is available from.

What causes a clock stop?

The first definitive treatment (intervention to manage a patient's condition and avoid further action).

When a patient declines treatment.

A period of active monitoring starts.

A clinical decision not to treat is made.

A patient does not attend their first outpatient appointment and the trust can demonstrate that the appointment was clearly communicated to the patient (which nullifies a clock).

A patient does not attend a subsequent appointment – subject to all conditions within the rules suite being met.

When does the clock stop?

The date the first definitive treatment starts; for example, admission to hospital; or, date that physiotherapist starts treatment if this is considered first definitive treatment.

The date:

- A patient informed a trust that they do not want treatment.
- A decision is made to start active monitoring.
- A decision is made not to treat a patient.

* Taken from 'NHS waiting times for elective care in England', January 2014, produced by the National Audit Office.